# Psychotherapy – the transformation of meanings: discussion paper

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Paper read to Section of Psychiatry, 14 May 1985

## Introduction

The field of psychotherapy presents a bewildering spectacle. Millions of persons suffering from a vast array of symptoms and disabilities turn for relief to thousands of practitioners. These practitioners represent a wide variety of professional disciplines and healing cults, each of which vigorously promotes its own particular brand of treatment. These treatments number over 150[1], and so far evidence as to the relative effectiveness or harmfulness of different brands is scanty and controversial.

In my efforts to make sense out of this cacophony, I have come to feel like Hercules wrestling with the Old Man of the Sea. Although one of the shapes assumed by psychotherapy has remained constant – that of a healing art – at different times psychotherapy has seemed to resemble a branch of medicine, a form of education, a type of scientific investigation and an expression of a philosophy of life, with the psychotherapist appearing as physician, educator, scientist and priest.

The best hope of bringing conceptual order into the field of psychotherapy may lie in thinking of all psychotherapeutic enterprises as lying in the realm of meanings. All psychotherapies are grounded in the fact that thinking, feeling and behaviour are responses to the meanings of events as much as to the events themselves. We are guided largely by our assumptions about reality[2], and the distress and disability of our patients are determined by how they construe their experiences[3].

The concepts and methods of all psychotherapeutic schools aim at enabling patients to transform the meanings of their experiences in such a way as to enable them to feel better and function more effectively.

## Psychotherapy and rhetoric

The discipline that psychotherapy most resembles seems to be rhetoric[4,5]. Although rhetoric is commonly associated with public discourse, and psychotherapy with efforts to influence individuals or small groups, both disciplines rely on 'the use of words to form attitudes or induce actions'[6].

The means of persuasion that enable the psychotherapist to transform the meanings of the patient's symptoms and experiences are remarkably similar to those of the rhetorician. Thus psychotherapists use many of the same devices, such as vivifying metaphors and sensory images, to focus the patient's attention on ideas central to the therapeutic message and make them appear more believable. In this connection neurolinguistic programming, for example, stresses the importance of the therapist using images from the same sensory modality as that of the patient's own imagery[7].

Although psychotherapists and rhetoricians both seek to form attitudes or induce action by words, there are some important differences. Psychotherapists work with individuals and small groups, whereas orators are concerned only with classes of people. Furthermore, unlike orators, psychotherapists of most schools view the patient as an active collaborator rather than an object of manipulation. The psychotherapist, if he is to live up to the ethics of his profession, is truly dedicated to serving the interests of the patient. Rhetoricians, while pretending concern for the welfare of their followers, actually seek only to promote their own ends – that is, to increase their own wealth or power.

## Demoralizing meanings of psychopathological symptoms

The meanings of a patient's symptoms are determined by both his individual experiences and his culture. These meanings determine whether the patient seeks help at all and, if he does, the kind of help he seeks. Symptoms and disabilities that in contemporary North American society lead persons to seek medical treatment or psychotherapy[8,9] are viewed in some other societies as expected responses to the stresses of life that must simply be endured. In still other cultures the same symptoms are evidence of having sinned, of loss of soul, or of spirit possession, for which the proper treatment is a religious ritual conducted by a priest or shaman[10].

A plausible hypothesis is that in all cultures the common meaning underlying the diverse symptoms that bring persons to psychotherapy is that the symptoms are demoralizing; that is, patients seek psychotherapy, not for symptoms alone, but for symptoms coupled with demoralization[11,12]. Often an important feature of demoralization is a sense of confusion resulting from the patient's inability to make sense out of his experiences or to control them, leading to the commonly expressed fear of going insane.

Most other psychopathological symptoms, whatever their source or nature, interact with demoralization in various ways. They increase the likelihood of demoralizing failure experiences by reducing the patient's coping capacity. Conversely, components of demoralization exacerbate many symptoms; thus the thinking of schizophrenics becomes more disorganized if they are made anxious, and obsessions and compulsions often are intensified by depression.

## Morale-enhancing meanings of psychotherapy

Psychotherapies combat demoralization to the extent that they directly relieve the patient's symptoms, as well as by combating the demoralization accompanying them. All psychotherapies provide new concepts and information that enable the patient to make meaningful connections between symptoms and experiences that had been mysterious, thereby replacing confusion with clarity.

0141-0768/86/060341-06/$02.00/0

All psychotherapeutic schools seek to help patients transform the meanings of their symptoms and problems so as to replace despair with hope, feelings of incompetence with self-efficacy[13], and isolation with rewarding personal relationships. To bring about these transformations, psychotherapists rely on words, sometimes accompanied by prescribed exercises as in bioenergetics[14] or bodily manipulations as in structural integration[15].

Even when psychotherapy has little specific effect on symptoms, by transforming their meanings it can enable the patient to tolerate them better and can strengthen the patient's morale in the face of persisting distress by enabling the patient to transform suffering into, for example, an opportunity for cultivating self-discipline or a spiritually redemptive experience.

## Morale-enhancing properties of the patient–therapist relationship

Features shared by all forms of psychotherapy that can be viewed as means of directly or indirectly combating demoralization include, first, an emotionally-charged, confiding relationship with a helping person; second, a setting identified in the patient's eyes as a place of healing; third, a therapeutic rationale that explains the causes of the patient's symptoms and, fourth, prescribes a procedure for relieving them that requires active participation by both the patient and the therapist.

In conjunction, all therapeutic rituals and procedures, irrespective of differences in specific content, combat demoralization by strengthening the patient–therapist relationship. In addition, the effectiveness of any form of therapy seems to depend to some degree on its ability to arouse the patient emotionally.

That for some patients with some symptoms in some circumstances the healing meaning of the therapeutic setting and relationship alone can be quite powerful is suggested by the therapeutic effectiveness of single interviews[16], as well as by the placebo effect. Although none is free of methodological flaws, several studies have found that, on average, the administration of a placebo – a pharmacologically inert substance which carries the meaning of the therapist's healing power – is followed by as much improvement as psychotherapy[17]. A finding with the same implications in one of our studies is that outpatients showed a marked average drop in discomfort immediately after receiving a battery of diagnostic tests and interviews and before any therapeutic procedures were instituted[18].

## Therapeutically relevant personal qualities of therapist, patient and therapist–patient dyad

The commonplace observation that among therapists with equal credentials and training some seem to be more effective than others, suggests that still ill-defined personal qualities also contribute to the therapist's persuasiveness. These qualities include the therapist's skill in constructing with the patient a convincing, meaningful narrative or story that explains the causes of the patient's symptoms or difficulties and suggests a collaborative procedure for overcoming them[19].

The power of therapeutic rationales and procedures, of course, depends not only on the personality and skill of the therapist but also on the receptivity of the patient. Responsiveness to any form of psychotherapy may depend in part, for example, on the patient's having had rewarding experiences of trust earlier in life.

There is evidence that therapeutic effectiveness may also depend on features of particular patient–therapist dyads that could enhance the therapist's persuasive power. Thus in an extensive study of women in psychotherapy, young, single women benefited more from female than male therapists, suggesting that the men may have been somewhat threatening to them. The only female patients who did better with the men were parents without partners. It is at least conceivable that the men gained persuasive power through representing potential new partners[20]. Finally, it seems that similarity of levels of conceptualization between therapists and patients are related to outcome[21–23].

## Therapeutic schools: conceptualizations of therapeutic schools

Therapeutic schools differ in the conceptual schemes in terms of which they seek to establish meaningful connections between the patient's symptoms and their supposed causes. These conceptual frameworks can be grouped into five broad categories: existential-humanist, dynamic, behavioural, cognitive and transactional. Each category, of course, includes many variations, and overlaps to a greater or lesser extent with the others. Existentialist-humanist therapists de-emphasize specific symptoms or complaints and seek rather to help the patient reach a higher level of self-realization[24] or to cope with the universal fear of death, of which symptoms are viewed as indirect manifestations[25]. Therapists of this persuasion believe they achieve these therapeutic goals by providing the patient with experience of a totally open, non-defensive encounter[26,27].

All other therapeutic schools seek directly to alleviate symptoms by correcting what their school believes to be the symptom's causes. To oversimplify greatly, therapists of the psychoanalytic persuasion, broadly defined, regard symptoms as unsuccessful attempts to resolve unconscious conflicts which express both the drive and the repressing force, to be resolved by bringing the conflicts to consciousness in the context of the therapeutic relationship. Behaviourists view symptoms as persistent maladaptive behaviours based on inappropriate reinforcement schedules learned in early life or on conditioning experiences and seek to correct these behaviours through new conditioning or reinforcement schedules; while cognitive therapists stress erroneous perceptions of the self, others and the future to be corrected by appropriate cognitive exercises[28].

In short, from the standpoint of the therapist, all the manifestations of psychopathology that yield to psychotherapy are meaningful, although the meanings differ for different therapeutic schools. All therapies consist of communications by the therapist to the patient that seek to enable the latter to discover meaningful connections between symptoms and their hypothesized causes, thereby also providing the means for the patient to gain relief.

### Meanings *v.* causes of psychopathological symptoms

It is now time to face up to a knotty issue that has been evaded so far, namely the relation of the meanings of psychopathological manifestations to their causes[29]. All schools of psychotherapy based on the scientific world-view, which includes most of those in Western industrialized societies, are based on theories that explain the patient's psychopathological manifestations in terms of hypothesized causes, such as unresolved unconscious conflicts or maladaptive conditioned responses. These therapeutic schools assume further that the effectiveness of their particular procedures depends on their success in combating these causes.

A limitation of all such formulations arises from the fact that humans, like all biological organisms, are open systems, including biological and psychological components interacting with each other and with the organism's social and physical environment. Because of this interaction, identification of the precise cause or causes of any particular perturbation in the system may be theoretically or practically impossible.

The causes that determine a person's feelings, thoughts and behaviour can be grouped into two major classes: constitutional or structural and environmental. Constitutional characteristics set limits on the range and type of a person's responses to environmental stimuli. Constitutional factors probably are also the major determinants of the form of these responses; that is, whether they are hallucinations, obsessions, dissociative phenomena, some forms of anxiety, and the like.

Environmental causes of thinking, feeling and behaviour can be further divided into impersonal and personal. Although persons may attribute meanings to impersonal noxae, such as bacteria or tobacco smoke, and these meanings may then determine whether the person exposes himself to them as well as the nature of his responses, they are not in themselves meaningful.

In theory, constitutional characteristics of the person can be determined by objective tests and procedures, though we still are a long way from being able to do this adequately. In any case, the data on which psychotherapeutic systems are constructed consist entirely of patients' reports of their present and past experiences, raising the question of the relation of psychotherapeutic formulations to the actual facts of the patient's life[30,31]. The patient's report does contain irreducible margins of uncertainty created by at least two major sources of distortion. The first is that memory is strongly affected by the patient's motivations. A person's past history is essentially not so much remembered as constructed by selection and emphasis from the enormous number of experiences that the person has undergone. It can, therefore, legitimately be viewed as an 'apologia'[32] to justify the person's present view of himself and the world.

Reports of past experiences are distorted by the kind of impression the patient seeks to make on the therapist. Consciously or unconsciously, the patient is inclined to formulate information about himself in terms that are consistent with the therapist's own conceptualizations. For example, it has long been known that patients' dreams are consistent with the therapeutic school of their therapist[33].

Life histories do not provide adequate causal explanations of patients' symptoms. Given the life history, one cannot predict the patient's symptoms. To take a clinical example, a kindergarten teacher was beset by a recurrent obsession that she had run over a child when returning from work and plagued her husband for reassurance that she had not done so. The meaning or function of this symptom could plausibly be accounted for by certain life experiences. She was the elder of two sisters. Her younger sister was emotionally fragile and had, therefore, always been favoured by the mother, who in addition had criticized the patient for her bad temper, which she had come to regard as a personal flaw. Her obsessions began shortly after her marriage to a man whom she felt neglected her because of preoccupation with his work. She could not, however, express her anger or resentment directly to him because before her marriage he had told her that a wife should never be angry at her husband.

A plausible psychodynamic explanation of her obsessions would be that they were both an expression of and a protection against her death wishes toward her resented younger sister, while from an interpersonal standpoint they could be viewed as oblique ways of seeking to get her husband's attention and, at the same time, to express her anger at him by making him miserable with her demands for reassurance. Yet, given the same life history and current circumstances, the patient might equally well have developed hysterical fits as an indirect expression of rage[34], or agoraphobia or compulsive checking of her automobile brakes, to name alternatives that immediately come to mind.

Just as a given life story is compatible with a wide range of symptoms, so a given symptom is compatible with a wide range of life stories, as Freud[35] has noted: 'Suppose, in a case of hysteria, we have really traced a typical symptom back to an experience or a chain of similar experiences – a case of hysterical vomiting, for instance, to a series of disgusting impressions – then we are at a loss when the analysis in a similar case of vomiting reveals a series of a quite different kind of ostensibly effective experiences. It looks, then, as though for unknown reasons hysterical patients are bound to produce vomiting and as though the historical precipitating causes revealed by analysis were only pretexts which, if they happen to be there, are exploited by this internal necessity'.

It can be maintained, of course, that if we knew enough about the structural features of a patient's personality and sufficient details of the life history, these in conjunction would unequivocally determine the patient's current symptoms; but this is an unproven hypothesis. In any case, the incompleteness of our information about patients allows protagonists of all schools to cling to their theories of causation by asserting that the missing information, if only it were available, would confirm their views.

These considerations lead to the speculation that the chief criterion of the truth of any psychotherapeutic formulation is its plausibility. Plausibility is related to truth in that the plausibility of a formulation depends in the first instance on how well the formulation accounts for the available facts. Facts in any domain limit the range of plausible meanings to be drawn from them, and the fewer the number of facts, the more leeway for alternative interpre-

tations. A glance at the domain from which objectively verifiable facts, as opposed to self-reports, about patients' lives can be obtained reveals that the number of facts is usually very small, thereby permitting a wide range of plausible interpretations.

To the extent that facts about a person's past life are not available, the criteria for the truth of any psychotherapeutic reconstruction of his past history are similar to criteria for the 'truth' of an interpretation of a religious text – that is, psychotherapy resembles hermeneutics[19].

The only criterion for the 'truth' of a hermeneutic interpretation of a text is its plausibility: thus the 'truest' interpretation would be the one which is most satisfying or makes the most sense to persons whose judgment one accepts. In psychotherapy the ultimate criterion of the truth of an interpretation is the extent to which the patient is convinced by it. The power of an interpretation to carry conviction to the patient depends on many factors, among them its ability to make sense out of the material the patient has offered, the terms in which the interpretation is expressed, the patient's confidence in the therapist, and, perhaps most importantly, the beneficial consequences of the interpretation for the patient's sense of well-being.

## Meanings, causes and therapeutic outcomes

The formulation of therapy in terms of meanings may cast some light on the discrepancy between clinical impressions and statistical findings with respect to therapeutic outcomes, and on the ability of psychotherapy to affect different forms of psychopathology.

### *Statistical findings* v. *clinical impressions*

All psychotherapists rightly distrust the statistical findings that have failed to reveal significant differences in the overall effectiveness of different therapies, since all have had personal experiences of being successful with patients with whom therapists using other procedures have failed. One possible reason for the failure of statistical studies to confirm clinical impressions may lie in the design inadequacies of most comparative studies of psychotherapy[36]. The many potential sources of error in these studies could well obscure considerable differences in actual effectiveness between the therapies being compared. A more fundamental source of negative findings of statistical studies may be that they have focused solely on comparing techniques, whereas the crucial determinant of outcome may be the persuasiveness of the particular therapist and his rationale and procedures to the particular patient – that is, the relative ability of the therapist and the meaningful connections he provides to inspire the patient's hopes, strengthen his sense of mastery, arouse him emotionally, and so on. This hypothesis would account for the finding of Sloane *et al.*[37] that, while there were few if any consistent statistical differences in the relative effectiveness of behavioural and interview therapies overall, a wider range of patients seemed accessible to behaviour therapy than to interview therapy. Moreover, by requiring continual active involvement of the therapist in the therapeutic task, behaviour therapies might succeed in establishing a therapeutic relationship with more disturbed or acting-out patients than interview therapies.

### *Therapeutic outcome and psychopathology*

Bypassing the ultimately metaphysical problem of whether or not all mental states are reducible to neuronal processes, there is no doubt that these processes can sometimes interfere with the accuracy of a person's appraisal of events and that the resulting distortions could contribute to psychiatric symptoms. The effectiveness of psychotherapy in alleviating these symptoms, then, would be limited by the ability of psychotherapeutic communication to modify these underlying neuronal processes. It seems reasonable to assume, for example, that insofar as anxiety and depression are responses to a person's interpretation of events, their underlying neuronal processes should be readily modifiable by the new, more favourable interpretations provided by psychotherapy. So it is not surprising that most cases of neurotic anxiety and depression respond well to all forms of psychotherapy[38]. On the other hand, the resistance of, let us say, mania or compulsive rituals to all psychotherapies may reflect the inaccessibility of their neurological substrates to therapeutic communications.

According to this view, psychotherapies cannot directly alleviate symptoms whose causes lie in psychologically inaccessible pathophysiological processes of the central nervous system; nor can they change the form of these symptoms. If hysterics relapse, they usually do so with the same types of symptoms they displayed in the first attack, and the same would be true of schizophrenic breaks or exacerbations of obsessions.

Even when the neuropathological processes underlying such symptoms are not directly modifiable by psychotherapy, however, the symptoms may be ameliorated indirectly by meaningful communications that reduce emotional tension. An example of the therapeutic effect on psychotics of therapeutic communications is the improvement shown by schizophrenics if their families can be taught to react less emotionally to them[39].

A striking example of the therapeutic effect of changing the meaning of a symptom that itself remains unchanged is the psychotherapy of panic states. There is no doubt that in many patients these afflictions are manifestations of a neurological disorder. They can be precipitated by infusions of sodium lactate, respond to tricyclics and other medications, and are resistant to psychotherapy[40]. It is not the panics themselves, however, but the anticipatory fear of them, that creates most of the patient's suffering and causes the patient to restrict activity. If the psychotherapist can convince the patient that the panics, however unpleasant, are not life-threatening events but are transitory and harmless, the patient feels much less distressed by them and is able to resume normal activities even though the panics themselves remain unchanged[41].

Some of the symptoms of post-traumatic stress disorders, finally, are probably caused by damage to the central nervous system through overstimulation. These symptoms, including startle reactions and bursts of dissociated activity, do not seem to be accessible to psychotherapy. By changing the meanings of these symptoms, however, psychotherapy can reduce the patient's shame over these uncontrollable behaviours and can help assuage survivor guilt[42]. As a result, the patient feels and functions better despite persistence of symptoms.

## Conclusion

The hypothesis that the benefits of most forms of psychotherapy for most patients result from the transformation of meanings does not exclude the possibility that some therapeutic methods may be able directly to modify the causes of some symptoms. This possibility is kept open by the observation that, for example, a form of psychotherapy which carries conviction to both patient and therapist may nevertheless fail to relieve a phobia that yields to a behavioural approach. In this connection, Klein's conclusion[43] that phobias are cured by any procedure that persuades the patient to stay in contact with the phobic object for 2 hours, while supporting the thesis of this paper, does suggest that the cure of phobias may actually result from conditioned extinction of neurological processes maintaining them, irrespective of their meanings to the patient. Similarly, it remains possible that procedures that create intense emotional arousal, such as primal scream[44] or flooding[45], may directly abolish certain symptoms through modifying their neurological substrates. Perhaps their effectiveness depends on the possibility that in order to relieve a symptom that developed while under extreme emotional stress in early life, it is necessary to bring the patient back to the same emotional state[46]. As with panics, however, the alternative hypothesis is not excluded that the beneficial effects of both extinction and flooding lie in the fact that they change the meaning of the patient's symptoms from threats to sanity or even life, to symptoms that the patient is able to endure at their maximum strength and still survive. The resulting increase in self-confidence and sense of mastery might then carry over to many other situations in life.

## Summary

This paper presents the hypothesis that psychotherapy seeks to produce changes in attitudes and behaviour through transformation of meanings. Patients come to psychotherapy because they are demoralized by the menacing meanings of their symptoms. The psychotherapist collaborates with the patient in formulating a plausible story that makes the meanings of the symptoms more benign and provides procedures for combating them, thereby enabling the patient to regain his morale. As a result, he feels better and functions more effectively, leading to progressive improvement. Various implications and limitations of this hypothesis are explored.

*Acknowledgments:* I wish to thank Paul R McHugh MD and Phillip R Slavney MD for their helpful suggestions.

## References

1 Herink R, ed. *The psychotherapy handbook: The A to Z guide to more than 250 different therapies in use today.* New York: New American Library, 1980
2 Frank JD. *Persuasion and healing: a comparative study of psychotherapy.* 2nd ed. Baltimore: Johns Hopkins University Press, 1973
3 Kelly GA. *The psychology of personal constructs*, vol 1. New York: WW Norton, 1955
4 Glaser SR. Rhetoric and psychotherapy. In: Mahoney WJ, ed. *Psychotherapy process: current issues and future directions.* New York: Plenum, 1980:313–34
5 Frank JD. Aristotle as psychotherapist. In:Mahoney WJ, ed. *Psychotherapy process: current issues and future directions.* New York: Plenum, 1980:335–7
6 Burke K. *A rhetoric of motives.* Berkeley: University of California Press, 1969:41
7 Bandler R, Grindler J. *Frogs into princes.* Moab, Utah: Real People Press, 1979
8 Gross ML. *The psychological society.* New York: Random House
9 Zilberfeld B. *The shrinking of America.* Boston: Little, Brown & Co, 1983
10 Kiev A, ed. *Magic, faith, and healing: Studies in primitive psychiatry today.* New York: Free Press, 1964
11 Frank JD, Hoehn-Saric R, Imber SD, Liberman BL, Stone AR. *Effective ingredients of successful psychotherapy.* New York: Brunner/Mazel, 1978
12 Frank JD. Therapeutic components shared by all psychotherapies. In: Harvey JH, Parks MM, eds. *Psychotherapy research and behavior change.* Washington, DC: American Psychological Association, 1982:9–37
13 Bandura A. Self-efficacy: toward a unifying theory of behavior change. *Psychol Rev* 1977;**84**:191–215
14 Lowen A. *Bioenergetics.* New York: Coward, McCann & Geoghegan, 1975
15 Schutz W, Turner E. *Evy, an odyssey into bodymind.* New York: Harper & Row, 1976
16 Jacobson G. The briefest psychiatric encounter. Acute effects of evaluation. *Arch Gen Psychiatry* 1968;**18**:718–24
17 Prioleau L, Murdock M, Brody N. An analysis of psychotherapy versus placebo studies. *Behav Brain Sci* 1983;**6**:275–310
18 Frank JD, Nash EH, Stone AR, Imber SD. Immediate and long-term symptomatic course of psychiatric outpatients. *Am J Psychiatry* 1963;**120**:429–39
19 McHugh PR, Slavney PR. *Perspectives of Psychiatry.* Baltimore: Johns Hopkins University Press, 1983
20 Orlinsky DE, Howard KI. Gender and psychotherapeutic outcome. In: Brodsy A, Hare-Muslin RT, eds. *Women and psychotherapy.* New York: Guilford Press, 1980:3–34
21 Best JA. Tailoring smoking withdrawal procedures to personality and motivational differences. *J. Consult Clin Psychol* 1975;**43**:1–8
22 Carr JE. Differentiation similarity of patient and therapist and the outcome of psychotherapy. *J Abnorm Psychol* 1970;**76**:361–9
23 Posthuma AB, Carr JE. Differentiation matching in psychotherapy. *Canadian Psychological Review* 1975; **16**:35–43
24 Maslow AH. *The farther reaches of human nature.* New York: Van Nostrand Reinhold Co, 1971
25 Yalom JO. *Existential psychotherapy.* New York: Basic Books 1980
26 Havens LL. The existential use of the self. *Am J Psychiatry* 1974;**131**:1–10
27 Seguin CA. *Love and psychotherapy.* New York: Libra Publishing, 1965
28 Beck AT, Emery G. *Anxiety disorders and phobias.* New York: Basic Books, 1985
29 Whitehorn JC. The concepts of 'meaning' and 'cause' in psychodynamics. *Am J Psychiatry* 1947;**104**:289–92
30 Spence DP. *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: WW Norton, 1982
31 Grunbaum A. *The foundation of psychoanalysis: A philosophical critique.* Berkeley: University of California Press, 1984
32 Goffman E. The moral career of the mental patient. *Psychiatry* 1959;**22**:123–42
33 Wolff W. Fact and value in psychotherapy. *Am J Psychother* 1954;**8**:466–86
34 Abse DW. Hysteria. In: Arieti S, ed. *American handbook of psychiatry, vol 1.* New York: Basic Books, 1959:272–91
35 Freud S. *Introductory lectures on psychoanalysis. Complete psychological works of Sigmund Freud, vol XVI.* Strachey J, ed. London: Hogarth Press, 1966:271.

36 Parloff MB. Psychotherapy research and the incredible credibility crisis. *Clinical Psychology Review* 1984;4:95–109

37 Sloane RB, Staples FR, Cristol AH, Yorkston NJ & Whipple K. *Psychotherapy versus behavior therapy*. Cambridge, Massachusetts: Harvard University Press, 1975

38 Smith NL, Glass GV, Miller TI. *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press, 1980

39 Vaughn CE, Leff JP. The influence of family and social factors on the course of psychiatric illness. A comparison of schizophrenic and depressed neurotic patients. *Br J Psychiatry* 1976;129:125–37

40 Shader RI, Goodman M, Gever J. Panic disorder: current perspectives. *J Clin Psychopharmacol* 2(6) (Suppl):2S–9S

41 Weeks C. *Hope and help for your nerves*. New York: Hawthorne, 1969

42 Kolb LC. A neuropsychological hypothesis for chronic stress disorder. *Am J Psychiatry* (in press)

43 Klein DF, Zitrin CM, Woerner MG, Ross DC. Treatment of phobias. II. Behavior therapy and supportive psychotherapy: are there any specific ingredients? *Arch Gen Psychiatry* 1983;40:139–45

44 Janov A. *The primal scream: Primal therapy, the cure for neurosis*. New York: Putnam, 1970

45 Olsen P, ed. *Emotional flooding*. New York: Human Sciences Press, 1976

46 Reus VI, Weingartner H, Post RM. Clinical implications of state-dependent learning. *Am J Psychiatry* 1979;136:927–31

*(Accepted 15 November 1985)*